Video Laryngoscopy Tips + Troubleshooting

	Pitfalls	Pearls
1	Choosing the wrong blade	The VL was designed to LOOK AROUND THE CORNER. The D blade (CMAC) and standard blade (glideoscope) are hyperangulated blades designed for indirect viewing in an airway that can't be manipulated. Both VL also have regular Mackintosh blades – use with the same technique as DL.
2	Using no guide or the wrong guide	Always use a guide and ensure that the guide is bent exactly in the shape of the VL blade. The rigid stylet should NOT be bent – they are designed for the curved / D blade. If you don't have the dedicated stylet – shape the regular guide like a "J".
3	Holding the stylet the wrong way	When using the rigid stylet hold it at the top. Loop your thumb through the handle so you are ready to pop the stylet once through the cords.
4	Difficulty sliding the curved blade and tube in straight	Because indirect view (curved) blades (D blade and glideoscope) and tube are so curved it may be difficult to slide them in straight. Scissor your right index finger and thumb on upper and lower incisors respectively to open the mouth. Then with the blade handle pointed to 9 o clock, insert the blade. When the blade is towards the back of the tongue, rotate the handle to 12 o'clock. Now look at the screen as you slowly advance. The blade is not designed to sweep the tongue out of the way but rather to follow its course to the vallecula.
5	Only looking at the screen	Remember: "mouth, screen, mouth, screen" to prevent injuries with blade and tube insertion.
6	Positioning the curved VL blade in the vallecula	Don't place the indirect view (curved) blade tip deep in the hypoepiglottic ligament like with Mackintosh. This maneuver pulls the larynx anterior which compounds the problems of passing the tube. The goal shouldn't be to fill the screen with a beautiful view of the cords. If you have a Grade I view, pull back on the blade, leaving the cords in the top third of the screen. This provides more space to facilitate tube passage. Seeing the cords isn't the problem, getting the tube in is. A grade II view is all you need and is actually what you want.
7	Directing the tube to the cords	Similar to inserting the blade, insert the tube with the long axis pointing to 3 o'clock, tip down, and insert backwards towards your body. This helps put the tip more anterior. Looking in the mouth, watch the tip enter the pharynx. When you hit the back of the pharynx with the tube, rotate the tube to 12 o'clock and presto, the tube tip is right at the cords. Think of the movement of the tube more

		like a joystick, as opposed to the standard guide and tube which you hold like a pencil and point straight. Ask an assistant to pull the side of the mouth open to make room for the tube if necessary.
8	The tube & guide get stuck in the larynx	Bring the tube tip to the cords and maybe just a little past. Visualize the epiglottis (like the Mackintosh view). “Pop” the stylet. Then have someone hold the guide and continue to slide the tube off and down. If it gets hung up on the anterior larynx slowly twist the tube 90-180 degrees to pass the tube.
9	Using a bougie with a VL	Indirect view are much more curved than standard mac blades because they're designed to LOOK AROUND THE CORNER. Standard bougies are straight with a curved tip and so are NOT designed to work with indirect VL blades. Standard bougies can ONLY be used with standard direct vision/ displacing blades (mackintosh) .